Exchange and Insurance Markets Workgroup:
Report to the Health Care Reform Coordinating Council

October 31, 2010

Introduction

The Co-Chairs of the Exchange and Insurance Markets Workgroup hereby submit this report of the workgroup's efforts to the Health Care Reform Coordinating Council (HCRCC).

The workgroup sought input from the public to guide Maryland's implementation of the Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), commonly referred to as federal health reform. A discussion document was created to request public comments on the following issues: whether the Exchange should perform functions beyond the federal minimum functions; the form of governance; the competencies and location of Navigators; whether there should be more than one Exchange and whether the individual and small group markets should be merged; strategies to encourage take-up and avoid selection bias; whether Maryland should phase in reforms prior to 2014; and how the Exchange operations should be financed once federal start-up funding ends. Individuals were also encouraged to provide comments on other topics if they wished.

Throughout the workgroup's activities, which included five meetings (held on August 10, August 26, September 15, October 1, and October 22), these issues were refined and additional issues emerged.

The workgroup focused its attention on the specific elements of its charge, based on both the Interim Report submitted to Governor O'Malley on July 26, 2010, and on the letter of direction provided by HCRCC Co-Chairs DHMH Secretary Colmers and Lt. Governor Brown.

This report summarizes the public input that was received. It identifies areas where common themes and suggestions—as well as differences of opinion—emerged.

As the workgroup's efforts proceeded, it became clear that only a handful of decisions require specific actions in the next 12 months, including the governance approach taken during the 2011 legislative session and whether Maryland should phase in certain reforms prior to January 2014 (e.g., begin moving the individual market to a modified community rating approach or require small groups to move toward benefit packages that may resemble the forthcoming federal "Essential Benefits"). Many other decisions can and should be made later. To determine which time-sensitive issues require a recommendation by the HCRCC, the Co-Chairs relied on a timeline developed by the State Coverage Initiatives (see the Appendix).

Even if certain issues do not require immediate decisions by policymakers, the Co-Chairs greatly value the thoughtfulness in the public input. Thus, the Co-Chairs will ensure that this full report—with the breadth and depth of the helpful public comments—will be presented to the successor entity of the HCRCC in order to inform future policymaking.

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Summary of Shared and Differing Perspectives

Shared Perspectives

Because most contributors shared a similar perspective in several topic areas, common themes and recommendations emerged. Contributors generally provided the following suggestions and recommendations:

- A single Exchange that will facilitate the purchase of health insurance in both the individual and small group markets should be created.
- The Exchange should not be located within a traditional executive branch agency.
- The Exchange should offer standalone single-benefit plans, such as dental plans, when necessary to offer all Essential Health Benefits required by Qualified Health Plans.
- The Board of the Exchange should include broad representation. Specific suggestions for members of the Board included public officials, consumer representatives, members of racial and ethnic minority groups, individuals with knowledge and understanding of commercial insurance, and individuals with knowledge and understanding of public health insurance.
- Navigators should be trained and certified to understand public sector programs such as Medicaid and CHIP, and also commercial insurance markets and products.
- Navigators should be culturally competent to work with populations with low health literacy, and assure that translated materials and interpreting services are available.
- The Exchange Plans should collect and analyze quality data to identify any disparities related to race, ethnicity, and language.
- Eligibility and enrollment into the Exchange (and Medicaid) should be simplified—using new technology—in order to alleviate some of the challenges in the current Medicaid eligibility process.
- The external individual market should not be eliminated.
- The Exchange should permit regional contracting within the state.
- The Exchange should not limit its contracting in the individual market to insurers and managed care organizations (MCOs) that also participate in HealthChoice; commercial insurers should be allowed to sell through the Exchange without a requirement that they participate in Medicaid.
- The Exchange should be financed by fees that do not influence individuals' or small groups' decisions to buy coverage inside vs. outside the Exchange. These fees should be designed in a way that creates a level playing field between individuals' and small groups' decisions to purchase insurance inside the Exchange vs. outside the Exchange. The Exchange should not be financed with state general revenue.

Differing Perspectives

Although there were many shared perspectives, different opinions emerged in the following major areas:

- Whether the Exchange should perform functions beyond those required under federal law
- Whether the Exchange should be created as a nonprofit entity or as an independent or quasi-independent public entity like a commission or authority
- Whether the individual and small group markets should be combined into a single purchasing pool, or whether they should remain separate purchasing pools in separate rating groups
- Whether Medicaid should require that all Medicaid MCOs in HealthChoice offer a product in the Exchange, or whether Medicaid MCOs should have the right to choose to participate in Medicaid alone
- Whether Navigators should be employees of, or contractors to, the Exchange
- Whether employers of 51 to 100 employees should be considered "small employers" under state law prior to 2016 (thereby permitting them to purchase insurance through the Exchange), or whether Maryland should specify that from 2014 to 2016, small employers are limited to employers of 2-50 employees
- Whether or not certain federal reforms should be phased in before 2014

Governance Structure and Location

The most pressing issue to be decided on in the next legislative session is the governance structure of the Exchange. Most future decisions regarding the Exchange will depend on the governance structure, as well as on the leadership team and Board of the Exchange.

Further, the entity created in 2011 will be responsible for creating the process (including ongoing public input) for the work that needs to continue after the governance model is established.

Almost universally, contributors recommended that the Exchange not be housed in a traditional executive branch agency, given state personnel systems, pay scales, the potential politicization of the Exchange, and the risk that individuals, carriers, brokers, and small groups would not perceive a traditional executive branch agency as a credible business partner. For example, one contributor said that if the Exchange's employees were subject to state furloughs, then the external market would be more responsive and would have a natural advantage, and the participation in the Exchange would suffer.

Public support was divided between locating the Exchange in either a public sector commission/ authority or in a nonprofit organization. Those who desire to see the Exchange created as a governmental entity stressed a number of reasons: the Exchange would be performing "inherently governmental" roles (under OMB Circular 76), such as distributing governmental funds (advanceable tax credits), promulgating rules and regulations on plan participation, and coordinating with state agencies and programs—such as Medicaid, the Maryland Insurance Administration (MIA), and state licensure boards; the Exchange would be handling sensitive information, such as individual income and citizenship status; and a publicly accountable governmental entity would be seen as more accountable to the needs of consumers.

Those who support creating the Exchange as an independent nonprofit organization also recognized that the state would need to be intricately involved in its organization, establishment, and functioning. These contributors explained that situating the Exchange in a nonprofit would isolate it from changes in the political and economic climates while taking pressure off of already overburdened state agencies and the state budget. It would allow the Exchange to be consumer-oriented and publicly accountable, and more independent from political influence. In addition, the Exchange would not necessarily be subject to state procurement laws, which would allow it more flexibility in hiring and salary decisions (though some contributors pointed out exceptions to procurement laws in state agencies: one example being the stadium authority). They believe an organization dedicated solely to the Exchange would ensure that it is run as adequately, effectively, and efficiently as possible. Some contributors believe locating the Exchange in a nonprofit agency would help increase enrollment by attracting individuals and small groups who may otherwise be unenthusiastic about the idea of purchasing insurance through a government entity.

No matter which location contributors supported, the majority of public comments agreed that representation on the Board of the Exchange needs to be broad and include a variety of stakeholders and experts. State officials should be welcome onto the Board for their expertise and experience (the most cited state official fitting this criterion being a representative from the Maryland Medicaid office). The following stakeholders were suggested for representation on the

Board: insurers [note: this is not allowed under the ACA], consumer advocates, and employers. Contributors suggested that individuals with expertise in the following areas should also be on the Board: marketing, education and outreach, legislation, research, public programs, vulnerable populations, health care delivery, insurance markets, sales, and regulation. Contributors felt that the Board must also have representation from racial and ethnic minorities. Some contributors believe the Board could, at least in part, be appointed by the Governor. Another suggestion was that the Board could be appointed by a consumer protection agency official.

The majority of public comments stressed the need for the governance to be transparent and for Board members to be free from conflicts of interest. The Board of the Exchange should take advantage of existing infrastructure and expertise whenever possible.

The governance structure is a decision that needs some form of recommendation and resolution in the next 12 months, and legislative action is necessary during the 2011 session.

Functions of the Exchange

The precise functions of the Exchange do not need to be resolved in the next 12 months, and a recommendation is not necessary. The Governor and legislature could define these functions in 2011, but there is no need to resolve the precise functions that soon; these decisions could be made later by the Exchange in the form of regulations, or in later legislation in the 2012 session.

Public comments revealed support for an Exchange that performs only the minimum functions required under federal law, as well as for an Exchange that performs functions beyond those that are required.

The Exchange should not perform additional functions

The contributors who articulated that the Exchange should act as a clearinghouse and not assume additional responsibilities cited a variety of reasons:

- The Exchange has many complex functions clearly outlined by the ACA and the focus should be on executing these basic functions before adding more.
- Many of the additional functions proposed are already duties of existing agencies; the Exchange should not waste resources replicating these functions.
- Adding functions has the potential to compromise participation in the Exchange. For example, limiting the number of insurers in an Exchange by imposing purchasing standards may limit consumer choice and cause both insurers and consumers to remain in the outside market; instead, the Exchange should encourage what one contributor called "a farmer's market approach."
- The Exchange will most likely be under constant pressure to expand and assume more responsibility once in place; therefore, Maryland should make the simplest, most efficient Exchange possible to leave room for future growth.
- The needs of the public and the challenges of the Exchange will be better understood once the Exchange has been implemented; therefore, additional duties should be allocated to the Exchange only after implementation and only once the additional duties become apparent on the basis of experience.
- The state budget is unsure and, given that the Exchange will not receive any federal financial support starting in 2015, Maryland should minimize the potential that the state general fund would have to shoulder the cost of expansive services. This risk is mitigated if the Exchange only performs the minimum tasks required by the ACA.

The Exchange should perform additional functions

Contributors who recommended that the Exchange take on additional functions explained that this would mean taking advantage of the opportunity to strengthen Maryland's health care delivery system. One contributor noted that the failure of the Exchange to capture a sizable number of individuals and small businesses and provide them with affordable, high-quality health care could result in the overall failure of the Exchange. Therefore, it should take on as many additional responsibilities as necessary to ensure its success. Another contributor observed

that the experience in Massachusetts proves that an Exchange performing only clearinghouse functions is insufficient for controlling health care costs. The following additional functions were suggested:

- Control the quality of insurers within the Exchange: Most contributors who believe that the Exchange should take on additional functions also believe that controlling the quality of insurers is necessary. One frequent recommendation in this area was a requirement that the Exchange only contract with insurers that promote a patient-centered medical home model of care. Some other recommendations included establishing minimum outcome standards; requiring transparency and report cards; and requiring the adoption of electronic health records. Contributors disagreed on whether the Exchange should select insurers through competitive bidding or whether it should negotiate with insurers. Even the majority of those who do not support the Exchange performing additional functions believe insurers need to have uniform price and quality reporting to allow for easy comparison by consumers.
- Education and outreach: While the ACA outlines that the Exchange must provide some education and outreach, such as a telephone hotline, some contributors believe it should go further to ensure that it reaches out to and educates as many people as possible. Many of these comments focused on cultural competency, meeting the needs of people with disabilities, and providing resources in multiple languages, all through multiple media. These processes should be sensitive to underserved populations, like individuals with low literacy, limited English proficiency, mental illness, or those without access to a computer. Contributors said that an extensive approach would maximize participation in the Exchange and the purchase of health insurance by populations to whom the Exchange is available. Many who believe education and outreach are a necessary function believe this responsibility, in part, belongs to Navigators.
- Single portal to eligibility: The ACA requires that the eligibility transition between the Exchange and public programs like Medicaid and CHIP be seamless. There must be a "single portal to eligibility" that would allow individuals to apply for Medicaid and CHIP using the same application. Contributors suggested that the Exchange—rather than another entity— operate this single portal for eligibility; this would be an additional function, because the Exchange could receive a list of Exchange-eligible individuals from another entity. Throughout the comments, there was significant support for building a relationship between the Exchange and these public programs beyond the minimum requirements. Contributors suggested that the Exchange coordinate billing with Medicaid and CHIP or aggregate premiums from multiple employers. These additional functions could simplify the application and eligibility processes and reduce costs.
- Incentivizing: Some public comments focused on the possibility that the Exchange could incorporate incentives in order to accomplish a variety of goals. Such goals include: encourage use and availability of primary care facilities; encourage use and availability of medical homes; ensure adequate reimbursements; adopt new, cost-effective technology; enroll low-risk members; manage chronic conditions; enroll underserved populations; make high-performance, high-quality insurers available; increase patient satisfaction; decrease labor and administrative costs; promote healthy consumer lifestyles; and ensure good clinical outcomes.

- Support for small groups: A few contributors said that the Exchange should provide services to small groups that are available outside the Exchange, including the purchase of additional coverage; Section 125 administration; COBRA or state continuation administration; wellness or health advocate programs; and employee assistance programs.

The majority of contributors emphasized the importance of the Exchange not duplicating existing functions.

Whether or not the Exchange is to take on additional functions, where appropriate, it should utilize the services and expertise of public and private entities.

The decision regarding whether the Exchange should take on additional functions does not need to be resolved in the next 12 months, and a recommendation is not necessary.

Basic Organization and Market Structure

The precise role of the Exchange in the broader market does not need to be resolved in the next 12 months, and a recommendation is not necessary. The Governor and legislature could make these decisions in 2011, but there is no need to resolve these issues that soon; these decisions could be made later by the Exchange in the form of regulations, or in later legislation in the 2012 session.

The specific issues that define the role of the Exchange in the overall insurance market include selection and take-up, existence of the external market, and the relationship between the individual and small group markets.

Selection and Take-Up

Many of the comments relevant to plan selection and take-up were more appropriately addressed in other sections of this document. For instance, many contributors noted the influence on selection and take-up of the existence of the external market, training of Navigators, and additional functions the Exchange may take on, such as education and outreach and controlling the quality of insurers sold within the Exchange. Further, some comments regarding selection and take-up were not suggestions for Exchange policy but, rather, for Maryland policy. A few comments pertained to selection and take-up independent of other sections and represented action that could be taken by the Exchange.

The main consistent recommendation was that all insurers selling in the external market offer a product inside the Exchange. As one contributor said, "Insurers that don't participate in the Exchange should be prohibited from offering catastrophic coverage outside the Exchange." Another contributor noted that requiring an insurer to offer products inside the Exchange in order to offer products outside the Exchange is forcing the Exchange to be the main market and provider.

Another frequent recommendation was that the Exchange make enrollment and plan comparison simple and clear. Most contributors who discussed participation believe that simplification and ease of enrollment combined with versatile, aggressive education and outreach would maximize participation. A variety of options for simplifying enrollment and plan comparison were presented. One suggestion was the implementation of an electronic verification system that would direct individuals to the appropriate portal of care: the Exchange, Medicaid, CHIP, or other public programs. Also, having one enrollment form for all public programs would reduce administrative costs and prevent individuals from having to understand and fill out different forms. Lastly, the Exchange should use simple language in its communication pieces.

Additional suggestions for how to mitigate adverse selection and encourage enrollment through the Exchange include:

- Limit open enrollment periods
- Encourage plan participation
- Encourage low-cost coverage options to participate

- Encourage broad provider networks
- Allow enrollment through multiple sources (online, by telephone, by mail, or in person)
- Assist consumers with not only enrollment, but also renewal and other subsequent issues
- Develop low-literacy materials and services
- Develop non-English materials and services
- Encourage value-based insurance design
- Encourage the inclusion of additional coverage, such as dental and emergency care

Existence of the External Market

Some contributors support the idea of eliminating the external market and selling all individual insurance through the Exchange. These contributors believe this would ensure the practicality of the Exchange because individuals would have to go through the Exchange for insurance. They pointed out that insurers would be more accountable to consumers as the Exchange may act as an active purchaser and impose more stringent quality and cost requirements on the insurers and products offered. Further, the Exchange could be in the position to control costs as it would only allow high-value insurers and products to be sold. Some contributors believe that the risk would be lowered in the Exchange if the external market were eliminated.

The majority of the public, however, does not support eliminating the external market. First, contributors pointed out that, because insurers would be required to pool inside and outside the Exchange, rates would be the same whether or not there was an external market. Second, the additional functions of the Exchange have not yet been determined, so the regulatory assumptions being made in the above argument are not yet certain. Third, eliminating the external market would eliminate a market through which many people currently purchase insurance. It would most likely cause much political turmoil as all participants in the individual market are forced into the Exchange. Lastly, the external market provides a source of competition that may help lower costs and increase efficiency in the Exchange. Contributors who support the coexistence of the Exchange and the external market argue that there are numerous disadvantages and few—and even in that case uncertain—advantages to insisting that all individual insurance be sold through the Exchange.

Individual and Small Group Markets

The public agreed that having one Exchange for both the individual and small group markets was the best option. The establishment and administration of one Exchange is already complex; there is no need to establish two Exchanges that would have significant overlap. Creating just one Exchange would limit administrative costs and burden, as well as reduce confusion for consumers.

The comments were divided as to whether Maryland should combine the individual and small group markets or leave them separate. However, the majority of comments recommended keeping the markets (rating groups) separate.

Contributors who think the two markets should be combined stressed that the success of the Exchange lies in creating the largest, most viable market possible. Combining the two markets, these contributors said, would increase the size of the rating pool and could stabilize both markets while maximizing enrollment and lowering premium costs. Further, these contributors believe combining the two markets could encourage competition, create efficiencies, and encourage innovation.

Contributors who think the two markets should remain separate admitted that a larger pool generally does create more stability; however, this may not be necessary given Maryland's markets. The individual and small group markets may be fundamentally different, thus requiring distinct marketing, administrative functions, and plan design. In addition, the individual market is going to go through many changes over the next few years, and the small group market should not be destabilized by combining the two rating groups. In addition, some contributors pointed out that some insurers participate only in one of the two markets. These insurers may be at a disadvantage if the two markets are combined.

The precise role of the Exchange in the broader market does not need to be resolved in the next 12 months, and a recommendation is not necessary.

Coordinated Contracting with Medicaid

Medicaid and the Exchange must coordinate in certain areas, such as the design of the entry point and eligibility, to ensure that a single, seamless process is used to enroll eligible individuals in the appropriate program: Medicaid for adults below 133 percent of the federal poverty level (FPL); Medicaid or MCHIP for children below 300 percent of the FPL; and the Exchange for adults above 133 percent of the FPL and children above 300 percent of the FPL.

Another potential area of coordination between Medicaid and the Exchange is the contracting policies utilized by either or both programs. For example, Medicaid could require the MCOs that have HealthChoice contracts to also offer products in the Exchange (as a condition of receiving a HealthChoice contract), in order to enable Medicaid beneficiaries to remain with the same insurance company as they transition from Medicaid to the Exchange (e.g., when adults experience income increases, or when children "age out" of MCHIP into the Exchange as they reach adulthood). Similarly, the Exchange could choose to only allow carriers to sell products in the Exchange if those carriers participated in Medicaid, as a condition of selling products in the Exchange.

Whether the Exchange and Medicaid coordinate contracting practices in either or both of these manners is not a decision that must be made within the next 12 months, so a recommendation is not required. Nevertheless, public input was requested on this topic, and very thoughtful comments were received.

Contributors consistently opposed the possibility that the Exchange limit its contracts to insurers that participate in HealthChoice. The comments uniformly stressed that commercial insurers should be allowed to participate in the Exchange without being required to participate in HealthChoice as a Medicaid MCO.

Regarding the suggestion that Medicaid MCOs be required to offer a product in the Exchange, the comments were much less uniform.

Several individuals asserted that Medicaid MCOs should be required to offer a product in the Exchange for the following reasons:

- It would promote continuity in care and provider networks when an individual moves from Medicaid to an Exchange product. Contributors who support this approach emphasized the disruption that would occur if Medicaid beneficiaries with complex health care needs (and who see many specialists) had to change insurers, networks, and providers simply because their income changed.
- Medicaid's purchasing power in the HealthChoice program (worth several billion dollars a year) would expand choices in the individual and small group markets if Medicaid MCOs were required to enter the commercial market.
- Medicaid MCOs already cover children up to 300 percent of the FPL (in the MCHIP program), and family enrollment in the same insurance company would be promoted by having Medicaid MCOs in the Exchange; thus, households between 133 and 300 percent

of the FPL would not have parents in one insurance company (in the Exchange) and their children in another (a Medicaid MCO).

- Adoption of the Basic Health Plan option in Maryland (which is a provision in the federal health reform law that would allow a state to cover adults up to 200 percent of the FPL in Medicaid, outside the Exchange) would not solve the problem of a "seam" between the Exchange and Medicaid; the transition between the programs would then occur at a different income level but would still exist.

Others endorsed the recommendation that Medicaid MCOs not be required to offer products in the Exchange for the following reasons:

- Medicaid MCOs have core expertise in a given model and program, and these MCOs should be entitled to select their markets and business models, and to continue focusing on public programs if that is their core strength and preferred business model.
- Unless state law changes, Medicaid MCOs would need an insurance license or health maintenance organization (HMO) license, and this requirement should not be imposed on Medicaid MCOs as a condition of contracting in HealthChoice.
- Maryland could and should adopt the Basic Health Plan[1] option, which would allow Medicaid MCOs to cover adults up to 200 percent of the FPL in Medicaid rather than the Exchange. This income cohort is likely to be less familiar with commercial insurance and more likely to need the specific specialty services of Medicaid (e.g., behavioral health) and the safety net provider network of Medicaid MCOs (e.g., FQHCs), whereas the cohort above 200 percent of the FPL is likely to be more familiar with commercial insurers and seek the networks offered in that market.
- Transitions from Medicaid and MCHIP to commercial insurance products occur now, and these transitions do not create continuity of care problems if enrollment workers (and Navigators in the future) work closely with families to select the best insurance carriers and products.

This issue does not require an immediate recommendation.

[1] Under the "Basic Health Plan" option, states may contract with MCOs to provide health insurance coverage, outside of the Exchange, to certain nonelderly individuals below 200 percent of the FPL who may move in and out of the Medicaid program. The purpose of the Basic Health Plan option in federal law is to ease the transition in and out of Medicaid, and to improve access to care and continuity of care, for certain individuals familiar with Medicaid. The Basic Health Plan receives significant federal financial support; HHS will annually transfer 95 percent of Basic Health Plan enrollees' expected federal subsidies (e.g., premium tax credits and cost sharing subsidies) if the individuals instead are covered in the Exchange to Maryland via a state-established trust. The federal financial support for the Basic Health Plan option is not time-limited.

Regional Contracting

Contributors stated that consumer choice of insurance carriers would be promoted by allowing the Exchange to offer products from carriers that do not offer insurance products on a statewide basis. For example, if an HMO has a licensed service area that is not statewide, or if another insurance carrier has a statewide license for a preferred provider organization (PPO) but is only allowed by MIA to sell insurance within a limited region of the state (due to the scope of its provider network), then the Exchange should allow those HMOs and other carriers to be options for individuals and small groups (through the Exchange) in exactly the same regions of the state where they offer insurance outside the Exchange.

These comments indicated that choice would be promoted through these regional contracts within the state, because regional HMOs and PPOs would be available choices. One contributor said that carriers should be "all in or all out," meaning the regions of the state in which these companies sell insurance outside the Exchange should be identical to the regions in which they sell inside the Exchange. That is, these companies should not be allowed to offer products in the Exchange in a *smaller* region of their state than their external market. The regions inside the Exchange and outside the Exchange should be co-extensive.

One Medicaid MCO asserted that if Maryland requires Medicaid MCOs to offer a product in the Exchange for continuity of coverage, then the Medicaid MCO's region in the Exchange should be limited to the counties in which the MCO is available to Medicaid beneficiaries in HealthChoice. That is, the MCO should not be forced to have a larger region in the Exchange than its region in Medicaid.

This issue does not require an immediate recommendation.

Navigator Function

The location of the Navigator function, as well as licensure and training requirements, are very important decisions to be made in the establishment of the Exchange. While these issues do not require a policy decision in the next 12 months, they must continue to be pursued by the governance entity created during the 2011 session. Some informed and pertinent perspectives are presented below to help future policymakers design the framework for the Navigator function.

The majority of public comments stressed the need for the Navigator function to be free of financial relationships with insurers and other conflicts of interest. The comments also uniformly said that the Navigator function must closely coordinate with the enrollment broker in Medicaid's HealthChoice program in order to facilitate transitions as people change programs.

There was support for locating the Navigator position inside the Exchange, in which case Navigators would be employees of the Exchange. There was also support for locating the Navigator position outside the Exchange, in which case Navigators would be contractors to the Exchange.

Almost everyone who commented on the Navigator function asserted that Navigators need to be well-trained, not only in enrollment in private insurance, but also in Medicaid, MCHIP, and other public programs. One contributor noted that the Navigator function should "build on the current system in the commercial and public programs." Another contributor noted that the broad range of expertise needed by the function could be considered an "elevated form of licensure."

Many contributors indicated that the Navigators will be dealing with sensitive situations and people will be relying on them for guidance for as long as they have health insurance through the Exchange. Therefore, Navigators need to be able to present information clearly, concisely, and in simple language (as well as in multiple languages). Navigators need to provide forms of post-enrollment service to the insured, and follow through and facilitate enrollment with individuals and small groups.

Contributors said that this type of full-service support from Navigators is essential for the Exchange to be a credible source of coverage—especially when compared to the external market. If Navigators inside the Exchange fail to be as knowledgeable, accommodating, and customer-oriented as agents, brokers, and health departments in Medicaid and the external insurance market, then the viability and credibility of the Exchange is at risk as people may turn to the outside market for their insurance needs.

A few contributors said that the salaries of Navigators should be comparable to (or above) the salaries of brokers for many reasons, including the expansive skills and training required of Navigators.

Contributors pointed out that it is impractical to expect every Navigator to have full expertise in every public and private program, for every individual and small group, across all languages and the diversity of the population, and in every region of the state. Instead, contributors said that the Exchange must retain Navigators (inside or outside the Exchange) who collectively fulfill these duties. One contributor suggested having general and expert Navigators. General Navigators

could be licensed in the commercial market and have general knowledge about other topics, including where individuals can go to get further information. Expert Navigators could be more knowledgeable about public programs and could be responsible for the more vulnerable populations passing through the Exchange. Another contributor pointed out that the more successful the Exchange is at being a clear, simple way to purchase insurance, the more Navigators can focus on assisting disadvantaged populations.

The precise role and location of the Navigator function does not need to be resolved in the next 12 months, and a recommendation is not necessary.

Phase In Reforms

Maryland could choose to phase in certain reforms prior to January 2014 in order to avoid the potential shock of numerous changes affecting the market all at once. For example, Maryland could elect to gradually phase in a form of community rating in the individual market prior to 2014, or modify the mandated benefit rules in the small group market to conform to the federal Essential Health Benefits (once those are clarified by the federal government).

Strong arguments were made on both sides of this issue. Contributors who believe phasing in federal reform is the best course of action seek to mitigate the sudden "sticker shock" that individuals might experience in 2014 when underwriting practices end in the individual market, all individual products are subject to federal benefit design rules (thereby ending catastrophic-only insurance), and MHIP is combined with the current individual market.

In the small group market, phasing in reform is supported by some contributors in order to "gradually modify the CSHBP and adjusted community rating."

Supporters of a phase-in argued that incremental changes are easier to handle than drastic changes. Also, some of the changes that need to be made could take a significant amount of time and effort. Some contributors feel that getting a head start on these changes would ensure an effective system by the time the reforms should be in place.

On the other hand, some contributors believe that insisting individuals pay higher premiums sooner for the sake of incrementalism could create unintended problems that are economic, social, and political. As one contributor expressed, phasing in federal reform would "ease the shock but accelerate the pain." Others said that incremental changes would simply add to the underlying confusion about health care reform, and that the state should not create more confusion by adding new deadlines and changes in law, all with varying effective dates. These contributors believe that the benefits of phasing in the reform are unknown and are outweighed by the potential negative consequences.

Because a decision to phase in reforms likely would require statutory changes in the individual and/or small group rating rules and benefit requirements, it is appropriate to begin the policy discussion in the 2011 legislative session. The HCRCC should further discuss this issue.

Definition of Small Employer

Some contributors believe defining "small employer" as "an employer with 1-100 employees" as soon as possible is the best course of action. These contributors believe the Exchange needs to be as large as possible to ensure its success.

Others believe the definition of "small employer" should remain "an employer with 2-50 employees" until it is federally mandated to change to "1-100 employees" in 2016. First, changing the definition would be an additional responsibility the Exchange does not need to take on before 2014. Letting the definition change when the ACA has designated it to change would reduce the use of resources. Employers with 51-100 employees have options available to them, so including them in the Exchange may not be necessary and may lead to adverse selection. Second, expanding the definition of "small employer" would encourage self-funding and thus may also contribute to adverse selection.

This issue does not require an immediate recommendation.

Self-Sustaining Financing for the Exchange

Though a short-term budget needs to be decided on, the availability of planning grants and a deadline that is more than four years away allow the topic of self-sustaining financing to be considered long-term. Self-sustaining financing implies that the Exchange must be functional without federal funds by 2016.

Almost all contributors agree that the Exchange should be self-financed without resorting to state funds, both because of the state's ongoing structural deficit and because reliance on state funds might negatively affect the operations and stability of the Exchange. A few dissenting contributors said that the state should apply some of its savings from health reform to help finance the operations of the Exchange once federal support ends. Contributors also noted that utilizing state funds would only make sense if the Exchange were created as a public sector entity.

Most contributors believe the Exchange should not be subject to changes in the state budget and should instead be funded by user fees to insurers, consumers, or both. However, some contributors noted that assessing fees on insurers may mean they are paying twice. Built into premium rates are fees to finance the external market, such as broker commissions. To add a fee to fund the Exchange on top of set premium rates may mean insurers and consumers in the Exchange are paying fees to finance both markets. A few contributors voiced support for the Massachusetts model; in this case, instead of assessing a fee on top of premium rates, insurers in the Exchange would be required to give the Exchange a percentage of the premium that would have gone to finance the external market.

A few contributors pointed out that licensure fees for Navigators could also be used to partially finance the Exchange. Other contributors suggested charging fees not only to users and insurers, but also to stakeholders who benefit from the implementation of the ACA. Such stakeholders include self-insured employers, pharmaceutical companies, and medical supply manufacturers. Many contributors said the fees should be broad-based (i.e., apply to brokers and carriers outside the Exchange just as they apply to Navigators and insurers inside the Exchange). Comments universally supported the view that the financing strategy should not create an uneven playing field between coverage sold inside and coverage sold outside the Exchange; the financing approach should not influence individual or small group purchasing decisions.

The Exchange should be financed with the goal of minimizing the effect of the financing strategy on individual, small group, and plan participation decisions. The fees need to be low enough so that no one is discouraged from participating in the Exchange. Further, user fees would need to be low enough so that identical products would not be more expensive inside the Exchange than in the external market. However, as premium costs in the outside market include fees and commissions, a fee of the same magnitude to purchase a product through the Exchange in order to retain overall pricing comparability is a plausible outcome. This may mean that assessing smaller fees on multiple parties, consumers, insurers, and stakeholders is the best means of self-sustaining financing to avoid high costs to any one party. Contributors agree that financial information should be transparent and broad-based. Most contributors agree that user fees should be excluded in the medical loss ratio calculation.

One contributor said that the ideal model—both for governance and self-sustained financing—is the Maryland Stadium Authority because of its capacity to issue bonds and borrow money. This would enable the Exchange to make long-term capital investments (such as information technology) and secure the financing for future revenues.

The precise strategy to ensure that the Exchange is self-sustaining after federal funding ends does not require an immediate recommendation.

Conclusion

The Co-Chairs of the Exchange and Insurance Markets Workgroup suggest that deliberation on the decisions that do not require an immediate recommendation be conducted by the governing body of the Exchange when appropriate. They wish to thank everyone who tendered comments for their invaluable contributions to this process. The Co-Chairs hope the HCRCC can utilize the perspectives presented in this document to begin to construct an Exchange that best serves the needs of Marylanders.

Contributors

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The Arc of Maryland
Baltimore Association of Health Underwriters
Baltimore HealthCare Access
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Health Insurance Buyers and Brokers Coalition of Maryland
Homeless Persons Representation Project
Kaiser Permanente
League of Life and Health Insurers of Maryland, Inc.
Legal Aid Bureau, Inc.
The Maryland Alliance of Dental Plans
Maryland Catholic Conference
Maryland Chamber of Commerce
Maryland Citizens' Health Initiative Education Fund, Inc.
Maryland Citizens' Health Initiatives: Health Care for All!
Maryland Hospital Association
The Maryland Women's Coalition for Health Care Reform
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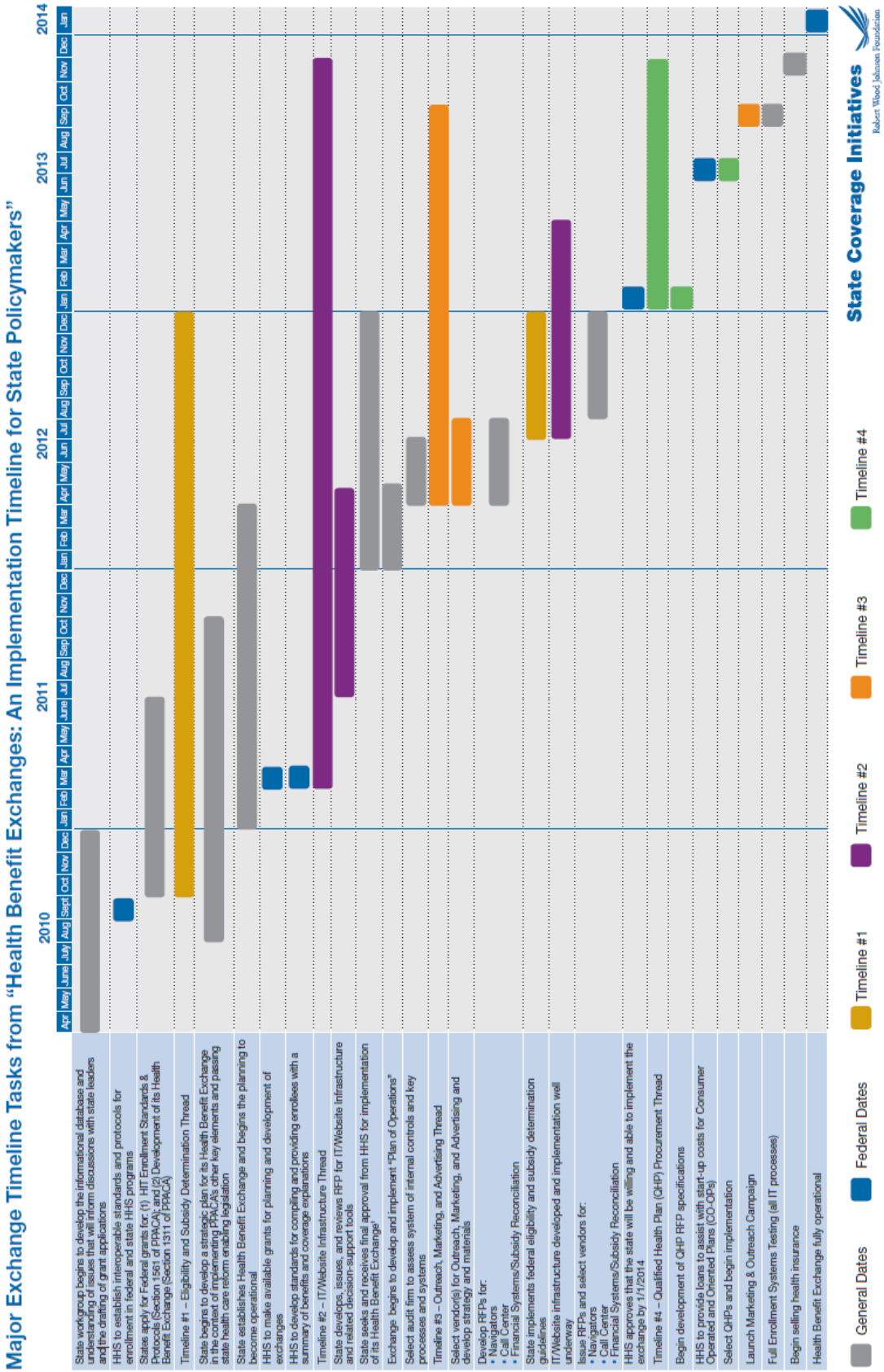
Appendix


Major Exchange Timeline Tasks from "Health Benefit Exchanges: An Implementation Timeline for State Policymakers"
2010
2011
2012
2013
2014
Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan
State workgroup begins to develop the informational database and understanding of issues that will inform discussions with state leaders and the drafting of grant applications
HHS to establish interoperable standards and protocols for enrollment in federal and state HHS programs
States apply for Federal grants for: (1) HIT Enrollment Standards & Protocols (Section 1561 of PPACA); and (2) Development of its Health Benefit Exchange (Section 1311 of PPACA)
Timeline #1 – Eligibility and Subsidy Determination Thread
State begins to develop a strategic plan for its Health Benefit Exchange in the context of implementing PPACAs other key elements and passing state health care reform enabling legislation
State establishes Health Benefit Exchange and begins the planning to become operational
HHS to make available grants for planning and development of exchanges
HHS to develop standards for compiling and providing enrollees with a summary of benefits and coverage explanations
Timeline #2 – IT/Website Infrastructure Thread
State develops, issues, and reviews RFP for IT/Website Infrastructure and related decision-support tools
State seeks and receives final approval from HHS for implementation of its Health Benefit Exchange
Exchange begins to develop and implement "Plan of Operations"
Select audit firm to assess system of internal controls and key processes and systems
Timeline #3 – Outreach, Marketing, and Advertising Thread
Select vendor(s) for Outreach, Marketing, and Advertising and develop strategy and materials
Develop RFPs for:
• Navigators
• Call Center
• Financial Systems/Subsidy Reconciliation
State implements federal eligibility and subsidy determination guidelines
IT/Website infrastructure developed and implementation wall underway
Issue RFPs and select vendors for:
• Navigators
• Call Center
• Financial Systems/Subsidy Reconciliation
HHS approves that the state will be willing and able to implement the exchange by 1/1/2014
Timeline #4 – Qualified Health Plan (QHP) Procurement Thread
Begin development of QHP RFP specifications
HHS to provide loans to assist with start-up costs for Consumer Operated and Oriented Plans (CO-OPs)
Select QHPs and begin implementation
Launch Marketing & Outreach Campaign
Full Enrollment Systems Testing (all IT processes)
Begin selling health insurance
Health Benefit Exchange fully operational
General Dates
Federal Dates
Timeline #1
Timeline #2
Timeline #3
Timeline #4
State Coverage Initiatives
Robert Wood Johnson Foundation